DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 5/22/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the smoke barrier doors. The findings included: During the facility tour on 4/5/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:50 AM, observation of the therapy area room 410 revealed the door was being held open with a peg. National Fire protection Association (NFPA). 101, 7.2.1.8.1	K 021	K021 Corrective action included closing the door to the Therapy room on 4/5/2010. This action was completed by the Director of Maintenance. The entire building was inspected for doors that were being held open on 4/5/2010. As for the measures put into place to ensure this practice does not recur, a staff in-service was completed on 4/13/2010 by the Administrator on the regulation that doors must be arranged to automatically close. Daily rounds will be completed Monday - Friday by the Director of Maintenance or designee. The rounds will continue weekly x4, then monthly x2, and then quarterly. All findings of the rounds will be reported to the Quality Assurance meeting monthly for analysis of findings. The Quality Assurance Team consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	K050 Corrective action included immediate in-servicing the staff responding to the fire drill 4/5/2010 regarding proper procedure for fire drills by the Director of Maintenance. All residents have the potential to be affected by this practice. Therefore, an in-service was completed with the staff working in the building on 4/5/2010 regarding the deficient practice by the Director of Maintenance. As for measures put into place to ensure practice does not recur, fire drills and in-services will be conducted 3xs per week for 4 weeks by the Director of Maintenance and RN Nurse Educator then for 3xs monthly.	4/19/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rachel Anderson Administrator 4/19/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to train the staff in fire drills. The findings included: During the facility tour the following deficiencies were noted and verified by the Director of Maintenance. At 10:00 AM, observation during the fire drill revealed the staff did not activate the alarm system as required. National Fire protection Association (NFPA). 101, 19.7.2.3	K 050	Results of the fire drills will be monitored by the Director of Maintenance and reported to the Administrator weekly. All findings will be reported to the Quality Assurance meeting monthly for analysis of findings. The Quality Assurance Team consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K052 The plant blocking the fire pull station in the activity room was removed on 4/5/2010. Equipment was moved away from the fire station in the kitchen area and laundry area on 4/5/2010. The whole building had the potential to be affected; therefore, all fire pull stations were checked to ensure equipment was not blocking on 4/5/2010. A staff inservice was completed 4/13/2010 by the Administrator to discuss the deficient practice. As for the measures put into place to ensure this practice does not recur, a staff in-service was completed on 4/15/2010 by the RN Nurse Educator regarding fire pull stations not being blocked. Additionally, daily rounds will be completed Monday - Friday by the Director of Maintenance or designee. The rounds will continue weekly x4, monthly x2, and then quarterly.	4/19/2010

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the alarm system. The findings included: During the facility tour on 4/5/10 the following deficiencies were noted and verified by the Director of Maintenance. At 10:15 AM, observation of the activity room revealed the pull station was blocked with a plant. National Fire Protection Association (NFPA). 72, 2-8.2.1	K 052	All results of the rounds will be reported to the Quality Assurance meeting monthly for analysis of findings. The Quality Assurance Team consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire extinguishers. The findings included: During the facility tour on 4/5/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:43 AM, observation of the kitchen area and	K 064	K064 Corrective action On 4/5/2010 included moving equipment away from the fire extinguishers in the kitchen area and laundry by the Director of Maintenance. A staff Inservice completed on 4/13/2010 to the QA Committee included discussing the deficient practice. This was completed by the Administrator. Daily rounds will be completed Monday-Friday by the Director of Maintenance or designee to monitor for items blocking fire extinguishers. As for measures put into place to ensure this practice does not recur, staff inservices conducted 4/15/2010 included discussion of not blocking fire extinguishers. Monitoring will include random rounds to be continued weekly x 4, monthly x 2, and then quarterly by the RN QA Coordinator. As for monitoring to ensure identified practice does not recur, all results of rounds will be reported to the Quality Assurance Committee for analysis of findings. The Quality Assurance Team consists of the following" Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010

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K 064	Continued From page 3 the laundry revealed fire extinguishers were blocked with equipment. National Fire Protection Association (NFPA). 10, 1.6.3	K 064		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the electrical system. The findings included: During the facility tour on 4/5/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:30 AM, observation of the dining hall and the 100 hall big bath revealed broken light covers. National Fire Protection Association (NFPA). 70, 110-12 At 9:35 AM, observation of the nurses station revealed the electrical panel was blocked with a trash can. NFPA 70, 110-26(a)	K 147	K147 Light covers in the dining hall and 100 hall big bath room were replaced 4/5/2010. The trash can blocking the electrical panel was removed on 4/5/2010 by the Director of Maintenance. The entire building was inspected for broken light covers in need of repair and for compliance of NFPA 70, National Electrical Code 9.1.2. All electrical panels were checked to make sure they were not blocked. This action was completed by Director of Maintenance on 4/5/2010. As for the measures put into place to ensure this practice does not recur, a staff in-service was completed on 4/15/2010 by the RN Nurse Educator regarding broken light covers and blocking electrical panels. Additionally, daily rounds will be completed Monday - Friday by the Director of Maintenance or designee. The rounds will continue weekly x4, monthly x2, and then quarterly. As for monitoring to ensure deficient practice does not recur, all results of the rounds will be reported to the Quality Assurance meeting monthly. The Quality Assurance Team consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.	4/19/2010